

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047875

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 185

FILED DEC 16 1963

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	
Length of stay in lb <u>5 yrs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pottersville Rt.</u>		d. STREET ADDRESS (If outside, give location) <u>Pottersville Route</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>James Emmett Shoffner</u>			4. DATE OF DEATH Month Day Year <u>December 11, 1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1892</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Rail Road</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (City and state or country) <u>Water Valley, Miss.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USC</u>		13a. FATHER'S NAME <u>William Shoffner</u>		13b. MOTHER'S MAIDEN NAME <u>Willie Mae Douglas</u>	
14. NAME OF HUSBAND OR WIFE <u>Florence Shoffner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>601</u>	
17. INFORMANT <u>Mrs. Florence Shoffner, West Plains, Mo</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DIS</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIOSCLEROSIS, GENERALIZED @ SEVERITY</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____	
20c. TIME OF INJURY Hour a.m. p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		20f. CITY, TOWN, OR LOCATION <u>12-11-63</u>	
20g. COUNTY <u>Howell</u>		20h. STATE <u>Mo</u>	

21. I attended the deceased from _____, to _____, and last saw her him alive on <u>NEVER SEEN ALIVE</u>	
Death occurred at <u>11:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Jack N. Wilcox, M.D.</u>	22b. ADDRESS <u>West Plains, Mo</u>
22c. DATE SIGNED <u>12-13-63</u>	
23a. BURNING, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/14/63</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town, or county) <u>near West Plains, Mo</u>
24. FUNERAL DIRECTOR <u>Carter Funeral Home, West Plains, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-11-63</u>
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DEC 23 1963

DEC 20 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leona Carter

Licensed Embalmer No. 4516

P. O. Address West Plains Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.